

Reg. Dist. No. 7880

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 1 1947

BUREAU V B.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

Reg. Dist. No. 02876 1850

1. PLACE OF DEATH

County HartfordCity or town Harnden House

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William J. Becker

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HartfordCity or town Harnden House

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Frances Taylor (de.)

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 4 - 18608. AGE: Years 87 Months 2 Days 23 If less than one day

hrs. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

12. Name Nicholas Becker13. Birthplace Germany14. Maiden name Louise?15. Birthplace Germany16. Informant Mrs. Gertrude LaneAddress 2744 Parkwood Ave. Pikesville, Md.17. Burial Date thereof 5/31/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Springfield Cem.Location Near Perryman, Md.18. Funeral director Pennington & SonAddress Harnden House, Md.19. May 30 19 47 A. L. Lewis M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 19 47 at 8:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19 38 to March 27 19 47and that I last saw him alive on March 27 19 47

Immediate cause of death

Myocardial failure

DURATION

1 dayDue to arterioscleroticcardio-renal disease10 years

Due to

Other conditions Diabetes Mellitus5 years

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John Walker M.D.

M. D. or other

Address Harnden House Date signed May 28

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

APR 2 1947

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 832
CERTIFICATE OF DEATH

★ 02877
Reg. Dist. No. 1850

1. PLACE OF DEATH:

County Harford
City or town Hampden
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, institution, or street address where death occurred:
Harford Memorial Hosp
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State md County Harford
City or town Chesapeake
(If outside city or town limits, write RURAL and give nearest town)
Street No. not Calvary road
(If rural, give LOCATION)
2. (a) If veteran, name war none

3. (a) FULL NAMEMARIE E. Bronson**3. (b) Social Security Number**none

4. Sex F 5. Color or race C 6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 4-11-96 6. (c) If alive, give age _____ years

8. AGE: Years 50 Months 10 Days 02 If less than one day _____ hrs. _____ min.

9. Birthplace St Marys Co. md.
(Town, county, and state)

10. Usual occupation Houseworker

11. Industry or business

12. Name Bonza E. Brandon13. Birthplace Charles Co. md14. Maiden name Mary Williams15. Birthplace St Marys Co. md16. Informant Mr. Bonza E. BrandonAddress Chesapeake md. N.F.B.

17. Burial Date thereof Mar. 12, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory mt CalvaryLocation near Chesapeake md.18. Funeral director Henry Tanning & SonsAddress Chesapeake md

19. 3-11- 19 47 A. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9 19 47 at 12:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/25 19 47 to 3/9 19 47

and that I last saw him alive on 3/9 19 47

Immediate cause of death

Hypostatic pneumonia DURATION 12 days

Due to Cerebral Hemorrhage and

Due to

Other conditions Pr. Hemiplegia
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury _____ Injured at work?

23. SIGNATURE Dudley Phillips md
Harford mem. Hosp M. D. or other

Address _____ Date signed 3/11/47

RECEIVED

MAR 12 1947

BUREAU OF

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-6

CERTIFICATE OF DEATH

02878

Reg. Dist. No. 1830

1. PLACE OF DEATH:

County Harford
 City or town Hartsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 21 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Harford
 City or town Hartsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Delmer Thomas Bush

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Minnie B Bush6.(c) If alive, give age 59 years7. Birth date of deceased (mo., day, yr.) July 22 1887

8. AGE: Years 59 Months 7 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Chestnut Hill Harford co. Md.
 (Town, county, and state)

10. Usual occupation Farmers

11. Industry or business _____

12. Name John Elsworth Bush13. Birthplace Chestnut Hill Md.14. Maiden name Sarah Ceeny15. Birthplace Rocks Md.16. Informant Kenneth BushAddress Pggsville Md

17. Burial Date thereof March 23 47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory William Wetters MemorialLocation Cash Town Farm Hill Rd18. Funeral director Martin SkurtzAddress Lanctsville, Md.19. Mar 23 1947 Thomas R Brown

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21, 1947, at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June, 1946, to March 21, 1947, and that I last saw him alive on March 21, 1947.

Immediate cause of death Pulmonary edema

DURATION

3 days

Due to Heart failure

long

Due to Rheumatic heart disease

?

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Charles E. Jeff M.D. or otherAddress Street, Md Date signed 3/24/47

RECEIVED

MAR 25 1947

BUREAU OF

1-55-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

02879

1850

1. PLACE OF DEATH:

County Harford
City or town Harford
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred
Harford Memorial Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md. County Harford
City or town Bel Air
(If outside city or town limits, write RURAL and give nearest town)
Street No. 148 Maulsby Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Lottie Eileen Carlisle

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced M
6.(b) Name of husband or wife Henry E. Carlisle
6.(c) If alive, give age 41 years
7. Birth date of deceased (mo., day, yr.) Oct. 14, 1917

8. AGE: Years 29 Months 4 Days 19 If less than one day
hrs. min.

9. Birthplace H.C. Md.
(Town, county, and state)

10. Usual occupation House Duties

11. Industry or business

12. Name Samuel Curry

13. Birthplace md.

14. Maiden name Lottie E. Elliott

15. Birthplace md.

16. Informant Henry E. Carlisle

Address Bel Air - Md.

17. Burial Date thereof 3-8-47
(Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory Rock Run

Location Harford Co. Md.

18. Funeral director P. Madison Mitchell

Address Navre de Grace Md.

19. March 7 1947 A. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5 1947 at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/4 1947, to 3/5 1947
and that I last saw him alive on 3/5 1947

Immediate cause of death

Pulmonary Edema & Shock

Due to uterine hemorrhage

Due to Placenta Accreta

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Placenta previa + accreta

Date of op. 3/5/47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

3. SIGNATURE Dudley Phillips M.D.

Harford Mem Hop M. D. or other

Address 3/5/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 10 1947
BUREAU OF

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

02880

1. PLACE OF DEATH:

County Harford
 City or town Navre de Grace
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 yrs
 Hospital, institution, or street address where death occurred:
230 N. Stokes Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md. County Harford
 City or town Navre de Grace
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 230 N. Stokes St
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Frances Lillian Carr

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Oliver S. Carr
 6. (c) If alive, give age Dec. years
 7. Birth date of deceased (mo., day, yr.) June 29, 1876

8. AGE: Years 70 Months 9 Days 7 If less than one day
0 hrs. 0 min.

9. Birthplace Penn.
 (Town, county, and state)

10. Usual occupation House. Duties

11. Industry or business

12. Name Geo. Magaw
 13. Birthplace Penn.

14. Maiden name Martha G. Carr
 15. Birthplace Penn.

16. Informant Mr. Benjamin L. Cox
 Address 1530 W. 4th St. W.D. Del.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Mar. 30, 1947
 (month) (day) (year)
 Cemetery or crematory Angel Hill
 Location Navre de Grace, Md.

18. Funeral director R. Madison Mitchell
 Address Navre de Grace, Md.

19. Mar. 28 19 47 A. L. Lewis M. D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 27 19 47 at 10¹⁵ A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19 46 to Mar. 27 19 47
 and that I last saw him alive on Mar. 26 19 47

Immediate cause of death Excitation - Cardiac
Failure
 Due to General Muscular
Atrophy
 Other conditions
 (Include pregnancy within 8 months of death)

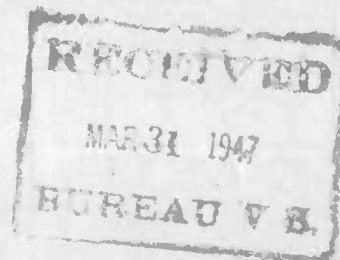
Major findings of operations

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Nature of injury Injured at work?

23. SIGNATURE A. L. Lewis M. D. M. D. or other
 Address Navre de Grace, Md. Date signed 3-28-47



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 02881 1810

1. PLACE OF DEATH:

County... Harford
 City or town... Rural Aberdeen
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Harford
 City or town... Rural Aberdeen md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Near Aberdeen
 (If rural, give LOCATION)
 2.(a) If veteran, name war... none

3. (a) FULL NAME

Clairard Duncy Duli

3. (b) Social Security Number

705-09-7388

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

8. (b) Name of husband or wife Dallie Michael

8. (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1898

8. AGE: Years Months Days If less than one day
48 5 5 hrs. min.

9. Birthplace Wilkes County, N. C.
 (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

12. Name John Duli

13. Birthplace North Carolina

14. Maiden name Mattie Walsh

15. Birthplace North Carolina

16. Informant Mrs. Clairard Duncy Duli

Address Aberdeen md. R.F.D.

17. Burial Date thereof Mar. 28, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oak Grove

Location Near Bel Air md

18. Funeral director Benny Tearing Stone

Address Aberdeen md

19. Mar. 27 19 47 Nellie H. Riley
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 19 47 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 23 19 45 to Mar 23 19 47

and that I last saw him alive on Mar 23 19 47

Immediate cause of death Cerebral hemorrhage

Due to Hypertensive cerebral

vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE GPB Gaston MD

Address Aberdeen md Date signed 3-25-47

RECEIVED

MAR 31 1947

BUREAU OF

1-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1830

1. PLACE OF DEATH: Hartford
 County.....
 City or town Neen - Bel Air, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md County Hartford
 City or town Bel Air - (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME Freeland M

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M

6. (b) Name of husband or wife M. Dona B. Francis

7. Birth date of deceased (mo., day, yr.) Oct 21 - 1874 6. (c) If alive, give age ✓ years

8. AGE: Years 72 Months Days If less than one day
 hrs. min.

9. Birthplace Ashe Co., N.C.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name John Francis

13. Birthplace N.C.

14. Maiden name Martha A Halsey

15. Birthplace N.C.

16. Informant Miss Nina Francis

Address Bel Air, Md

17. Burial Date thereof Mar 21/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bel Air Memorial Park

Location Bel Air, Md

18. Funeral director Dean Y. Foster

Address Bel Air, Md.

19. 3/20 19 47 Priscilla Francis
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 19 47 at 10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 19 47, to March 18 19 47, and that I last saw him alive on March 17 19 47.

Immediate cause of death Pulmonary embolism DURATION 2 hours

Due to Cholecystectomy

Due to

Other conditions

(Include pregnancy within 8 months of death)
 Major findings of operations cholecystitis

Date of op. Feb 27, 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gerald C Palmer M.D.

Address Bel Air, Md. M. D. or other
 Date signed 3/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

MAR 22 1947

BUREAU 7 2

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

02883

185-0

1. PLACE OF DEATH

County HarfordCity or town Harde Chase
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Harde Chase
(If outside city or town limits, write RURAL and give nearest town)Street No. 209 Bloomsbury
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Roger Hamilton Centry

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Hazel Centry6. (c) If alive, give age 42 years7. Birth date of deceased (mo., day, yr.) 11/6/1891

8. AGE:

55 Years4 Months17 Days

If less than one day

hrs. min.

9. Birthplace Charlottesville Va.

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER

12. Name

Eugene H. Centry

13. Birthplace

Charlottesville Va.

MOTHER

14. Maiden name

Bertine Taylor

15. Birthplace

Charlottesville Va.

16. Informant

Mrs. Hazel Centry (wife.)

Address

209 Bloomsbury St. H. de Chase

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

3/27/47
(month) (day) (year)

Cemetery or crematory

Murray

Location

Murray Ky.

18. Funeral director

Address

Washington & Co.
Harde Chase, Md.

19. Date rec'd by registrar

Mar. 24 1947A. L. Lewis
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 23 1947 at 44 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 10 1945 to Mar 23 1947and that I last saw him alive on Mar 23 1947

Immediate cause of death

Coronary Atherosclerosis
Cerebral Thrombosis

DURATION

Due to

Due to

Other conditions

Tobacco

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles J. Foley M.D.

M. D. or other

Address

Harde Chase, Md.
Date signed 3/24/47

RECEIVED

MAR 25 1947

BUREAU 78

1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-2

CERTIFICATE OF DEATH

Reg. Dist. No. 02884 1810

1. PLACE OF DEATH:

County Hanford
 City or town Aberdeen
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 74 yrs.
 Hospital, institution, or street address where death occurred:
20 Mt Royal Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Hanford
 City or town Aberdeen
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 20 Mt Royal Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Howard L. Gilbert

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 8. (b) Name of husband or wife A. Mary Schanz
 7. Birth date of deceased (mo., day, yr.) July 30, 1872 6. (c) If alive, give age 69 years
 8. AGE: Years 74 Months 7 Days If less than one day hrs. min.

9. Birthplace Aberdeen Hanford Co., Md.
 (Town, county, and state)

10. Usual occupation Store Keeper

11. Industry or business Aberdeen Paving Grounds

12. Name Edwison Gilbert

13. Birthplace Aberdeen P. D.

14. Maiden name Rachel Gilbert

15. Birthplace Aberdeen P. D.

16. Informant Mrs. A. Mary Gilbert

Address 20 Mt Royal Ave

17. Burial Date thereof Nov. 15, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Bakers Cemetery

Location Aberdeen Md.

18. Funeral director Henry Tarrington Sons

Address Aberdeen Md.

19. Mar. 14 1947 Nellie H. Riley
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13th 1947, at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 11th 1947 to March 13 1947, and that I last saw him alive on March 13th 1947.

Immediate cause of death Cerebral hemorrhage DURATION 2 days

Due to arteriosclerosis, hyper-tension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos P. Thompson M. D. or other

Address Aberdeen Md. Date signed Mar. 14/47

RECEIVED

RECEIVED

RECEIVED

MAR 18 1947

BCRFA 18

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

Reg. Dist. No. 1810

02885

1. PLACE OF DEATH:

County Harford
 City or town Chesden
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 24 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Chesden
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 139 Baltimore St
 (If rural, give LOCATION)
 2. (a) Is veteran, name war None

3. (a) FULL NAME

Henry Hall Griffith

3. (b) Social Security Number

711-08-0028

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Cora E McChene
 6. (c) If alive, give age 65 years
 7. Birth date of deceased (mo., day, yr.) June 19th 1892
 8. AGE: Years 54 Months 8 Days If less than one day hrs. min.

9. Birthplace Bel Air Harford Co. Md.
 (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

12. Name Samuel P. Griffith

13. Birthplace Harford Co. Md.

14. Maiden name Sarah C. Rogers

15. Birthplace Harford Co. Md.

16. Informant Mrs. Cora E. Griffith

Address 139 Balt. St. Chesden Md.

17. Burial Date thereof Mar. 22 - 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Carmel

Location Emmorton Harford Co. Md.

18. Funeral director Henry Tanning Sons

Address Chesden Md.

19. Mar. 21 19 47 Nellie H. Liles
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 19 47 at 11:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15 19 46 to March 18 19 47

and that I last saw him alive on March 18 19 47

Immediate cause of death Pulmonary edema Cerebral Hemorrhage DURATION 4 hrs.

Due to Essential Hypertension

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Upcher M.D. M. D. or other

Address Home de fme Date signed March 19

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

MAR 25 1947

BUREAU OF

1-55-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

02886

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County Harford
City or town Harre De Hae
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Harford Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Cecil

City or town Colma
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Baby Boy Grinstead

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Newborn

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Mar 26, 1947

8. AGE: Years _____ Months _____ Days _____ If less than one day 9 hrs. 50 min.

9. Birthplace Harre De Hae, Harford, Md
(Town, county, and state)

10. Usual occupation Newborn

11. Industry or business Pat. Grinstead

12. Name Pat. Grinstead

13. Birthplace va

14. Maiden name Ernestine Johnson

15. Birthplace va

16. Informant J. S. Johnson

Address Colma, md

17. Burial Date thereof Mar 27 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory West Nottingham

Location Colma md

18. Funeral director J. C. Tyson

Address 17 rising Sun md

19. Mar. 28 19 47 A. Z. Lewis Jr. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26 19 47 at 3:28 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/26 19 47 to 3/26 19 47 and that I last saw him alive on 3/26 19 47

Immediate cause of death prematurity

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Sadley Philby MD

Harford Mem. Hosp M. D. or other _____

Address _____ Date signed 3/26/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 31 1947

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1820

CERTIFICATE OF DEATH

02887

Reg. Dist. No. 1820

1. PLACE OF DEATH:

County Harford
 City or town Bel Air
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 days
 Hospital, institution, or street address where death occurred:
Fountain Green Hosp.
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Harford
 City or town Bel Air
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

LINDA LEE GROSS

3. (b) Social Security Number

4. Sex FEMALE 5. Color or race W 6.(a) Single, married, widowed, or divorced _____
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) March 18, 1947
 8. AGE: Years _____ Months _____ Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Harford Co. md
 (Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Wm Henry Gross13. Birthplace Harf. Co. md14. Maiden name Georgette Hooper15. Birthplace Harf. Co. md16. Informant Wm H. GrossAddress Bel Air md17. Burial Date thereof 3/19/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Calvary CemLocation Harford Co. md18. Funeral director H K McLeomax & SonAddress Abingdon19. 3/18 1947 Priscilla Lowood
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 18 19 47 at 12:42 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 16 19 47 to MARCH 18 19 47 and that I last saw her alive on MARCH 18 19 47

Immediate cause of death _____ DURATION _____

Congenital Heart
100% defect
(Cyanotic from Birth)
 Due to _____
 Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

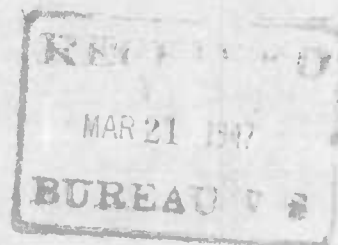
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Willard P. Hudson

M. D. or other _____

Address FOREST HILL, Md Date signed 3/18/47



1-55-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1830

1. PLACE OF DEATH:

County HarfordCity or town Pylesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County HarfordCity or town Pylesville, R.D.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Sarah Jane Rankins

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

James W. Rankins

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

04 28 1866

8. AGE:

Years

Months

Days

If less than one day

80418

hrs.

min.

9. Birthplace

Farmington Va
(Town, county, and state)

10. Usual occupation

Widow

11. Industry or business

Widow

MOTHER

FATHER

12. Name

Richard Rankins

13. Birthplace

Farmington Va

14. Maiden name

Eliza Rogers

15. Birthplace

Farmington Va

16. Informant

Ally Rankins

Address

Pylesville Md

17. (Burial, cremation, or removal. Which?)

Burial Date thereof March 18 1947
(month) (day) (year)

Cemetery or crematory

Pylesville M. C.

Location

Pylesville Md

18. Funeral director

Thomas R. Brown

Address

1000 Grove Rd

19. (Date rec'd by registrar)

March 20 1947 Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1947, at 4 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October - 1945 to March 18 1947and that I last saw him alive on March 16 1947

Immediate cause of death

Coronary Heart Failure 2d.

Due to

Cor. Sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

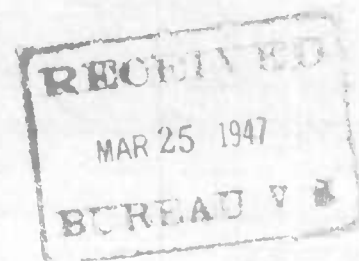
Jonah A. Hunt M.D. M. D. or other _____Address Delta, Pa. Date signed 3/18/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9a)

CERTIFICATE OF DEATH

Reg. Dist. No.

02889

18 1/2

1. PLACE OF DEATH:

County HarfordCity or town Harlington
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 44

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HarfordCity or town Harlington
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION) No

2.(a) If veteran, name war _____

3. (a) FULL NAME

Walter M. Hickman

3. (b) Social Security Number

220-03-6657

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

None

7. Birth date of

deceased (mo., day, yr.)

Jan. 22 1902

8. AGE:

Years 45Months 1Days 28

If less than one day

hrs. _____ min. _____

9. Birthplace

Cecil Co., Md.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

On Farm

12. Name

Walter M. Hickman

13. Birthplace

Danvers Co., Penna

14. Maiden name

Lula M. Barrow

15. Birthplace

Cecil Co., Md.

16. Informant

Mr. Walter M. Hickman

Address

Harlington, Md.

17. Burial

March 22 1947

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

Oak Wood Cem.Cecil Co., Md.

18. Funeral director

Address

H. S. BaileyHarlington, Md.

19. Registrar

Address

March 20 47

Date rec'd by registrar

M. V. Kirk

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 47 at 3P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 18. _____ to _____ 19. _____

and that I last saw him _____ alive on _____ 19. _____

Immediate cause of death

Coronary occlusion

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

EVIDENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

Gerald C. Palmer M.D.Address Harford County Date signed 3/19/47

CERTIFICATE OF DEATH

RECEIVED

MAR 31 1947

BUREAU V.B.

2-1820-2-10

cb

★

BIRTH AND DEATH

Reg. Dist. No. 1810

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF STILLBIRTH

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

<p>1. PLACE OF BIRTH:</p> <p>County <u>Harford</u></p> <p>City or town <u>Aberdeen</u> (If outside city or town limits, write RURAL and give nearest town)</p> <p>Street address, hospital, or institution: <u>Station Hospital, Aberdeen Proving Ground, Md.</u></p> <p>Length of mother's stay in County <u>8½ months</u> (How many years, or months, or days. SPECIFY WHICH)</p>	<p>2. USUAL RESIDENCE OF MOTHER: <u>02890</u></p> <p>State <u>North Carolina</u></p> <p>County <u>Mecklenburg</u></p> <p>City or town <u>Charlotte</u> (If outside city or town limits, write RURAL and give nearest town)</p> <p>Street No. <u>1916 Greene</u> (If RURAL give LOCATION)</p>
<p>3. Name of child</p> <p>5. Sex <u>Male</u> 6. Twin or triplet</p>	<p>4. Date of birth <u>27 March</u> 19<u>47</u> Hour <u>4:49 P. M.</u></p> <p>7. No. of weeks pregnancy <u>24</u></p>
<p>FATHER OF CHILD</p>	<p>MOTHER OF CHILD</p>
<p>8. Full name <u>S/Sgt Claud E. Jeffers</u></p> <p>9. Color <u>W</u> 10. Age at time of this birth <u>27</u> yrs.</p> <p>11. Usual occupation <u>Soldier</u></p>	<p>12. Full maiden name <u>Ethel Rebecca Moore</u></p> <p>13. Color <u>W</u> 14. Age at time of this birth <u>26</u> yrs.</p> <p>15. Usual occupation <u>Housewife</u></p>
<p>16. Other children born to mother (not including present child): (a) How many children of this mother are now living? <u>2</u> (b) How many other children were born alive but are now dead? <u>None</u> (c) How many other children were born dead? <u>1</u></p>	
<p>17. Did child die before labor? <u>No</u> During labor? <u>No</u></p> <p>18. Pregnancy, complications of <u>None</u></p> <p>19. Labor: (a) Complications of <u>None</u> (b) Induced? <u>No</u></p> <p>20. (a) Was there an operation for delivery? <u>No</u> (b) State all operations, if any. (Yes or No)</p> <p>(c) Did child die before operation? <u>No</u> During operation? <u>No</u></p>	<p>21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof. (a) Fetal causes <u>Prematurity - 520 Gms</u> (b) Maternal causes</p> <p>22. I certify to the birth of this child who was born dead* on the date and hour above stated.</p> <p>Signature <u>George F. [unclear]</u> (Specify if M. D., midwife, or other)</p> <p>Address <u>Station Hospital, Aberdeen Pr Gr, Md</u></p>
<p>23. (a) <u>Unusual</u> (b) Date thereof <u>April 2 - 1947</u> (Burial, cremation or removal) (month) (day) (year)</p> <p>(c) Cemetery or crematory <u>Greenwood</u></p> <p>24. (a) Funeral director <u>Henry Tammig House</u> (b) Address <u>Aberdeen Md</u></p>	<p>25. (a) <u>28 March 47</u> (b) <u>[unclear]</u> (Date rec'd by registrar) (Registrar)</p> <p>26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.</p> <p style="text-align: right;">Health Officer, per</p>

* See Instruction C on stub.

Child lived 10 minutes

V. S. A10

RECEIVED

APR 3 1947

BUREAU OF

2-35

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF STILLBIRTH

BIRTH AND DEATH

Reg. Dist. No. 159

1810

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Harford

City or town Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

Street address, hospital, or institution:

Station Hospital, Aberdeen Proving Ground, Md.

Length of mother's stay in County 8 1/2 months

(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State North Carolina

County Mecklenburg

City or town Charlotte

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1916 Greene

(If RURAL give LOCATION)

3. Name of child

5. Sex Male

6. Twin or triplet

4. Date of birth

27 March

1947

Hour 4:49 P M.

7. No. of weeks pregnancy

24

FATHER OF CHILD

8. Full name S/Sgt Claud E. Jeffers

9. Color W 10. Age at time of this birth 27 yrs.

11. Usual occupation Soldier

MOTHER OF CHILD

12. Full maiden name Ethel Rebecca Moore

13. Color W 14. Age at time of this birth 26 yrs.

15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 2

(b) How many other children were born alive but are now dead? None (c) How many other children were born dead? 1

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of None

19. Labor: (a) Complications of None

(b) Induced? No

20. (a) Was there an operation for delivery? No

(Yes or No)

(b) State all operations, if any

(c) Did child die before operation? No

During operation? No

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Prematurity - 520 Gms

(b) Maternal causes

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature

George Kramer, Jr.
 (Specify if M. D., midwife, or other)
Station Hospital, Aberdeen Proving Ground, Md.

Address

23. (a) Burial (b) Date thereof April 1, 1947

(Burial, cremation or removal)

(c) Cemetery or crematory Brown Cemetery

24. (a) Funeral director Henry T. Young, Jr.

(b) Address Aberdeen, Md.

25. (a) Apr. 1-47 (b) Nellie A. Riley

(Date rec'd by registrar)

(Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.

Health Officer, per

* See Instruction C on stub.

Child lived 10 minutes

V. S. A10

RECEIVED
APR 5 1947
BUREAU
1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

02891

185-0

1. PLACE OF DEATH:

County Hampden
City or town Hamden
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 day
Hospital, institution, or street address where death occurred:
Hampden Hosp
How long in hospital or institution? 2 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Cecil
City or town Hamden
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Martin Jordan

3. (b) Social Security Number

?

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 83 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name _____
13. Birthplace _____
14. Maiden name _____
15. Birthplace _____

16. Informant Hosp. Records
Address Hamden Hosp. Md.

17. Burial (Burial, cremation, or removal) Which? Burial Date thereof 3/6/47
(month) (day) (year)

Cemetery or crematory Angel Hill
Location Hamden Hosp.

18. Funeral director Pennington & Son
Address Hamden Hosp. Md.

19. (Date rec'd by registrar) March 6 1947 Registrar G. L. Lewis M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4 19 47 at 10:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/2 19 47 to 3/4 19 47 and that I last saw him alive on 3/4 19 47

Immediate cause of death Crown Thrombosis DURATION 24 hrs.

Due to Generalized arterio-sclerosis and mural thrombosis

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results None Thrombi of heart arteries

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Dudley Phillips M.D. M. D. or other _____

Address Hampden Hosp. Date signed 3/7/47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 8 1947
BUREAU V.C.
1-35

02892

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 1810

1. PLACE OF DEATH:

County Harford
City or town Aberdeen - Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Post Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County HarfordCity or town Aberdeen - Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Post Road
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

JOHN C. KAPENOVITCH

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Unknown

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Unknown 1887

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

About 65

hrs. min.

9. Birthplace

Unknown
(Town, county, and state)

10. Usual occupation

Labour

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Charles B. Olson

Address

Aberdeen Md

17.

(Burial, cremation, or removal, Which)

Date thereof Mar. 28, 1947
(month) (day) (year)

Cemetery or crematory

Brown

Location

Aberdeen Md

18. Funeral director

Henry Tanning Sons

Address

Aberdeen Md

19.

(Date rec'd by registrar)

Mar 28 1947Nellie Z. Riley

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1947 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

Probable Cerebral Hemorrhage

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

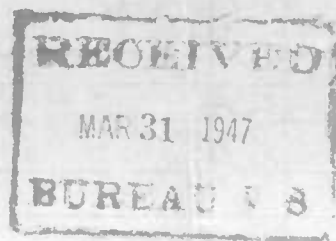
23. SIGNATURE

J. H. Lawrence M.D.Address Aberdeen, Md Date signed 3/28/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

Reg. Diat. No.

02893

1857

1. PLACE OF DEATH:

County Harford
 City or town Harde de Grace
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford
 City or town Harde de Grace
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 446 Lafayette
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Juanita Christine Laurie

3. (b) Social Security Number

-

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age. - years

7. Birth date of

deceased (mo., day, yr.)

Oct. 6 - 1940

8. AGE:

Years

Months

Days

If less than one day

6510

hrs.

min.

9. Birthplace

Harde de Grace
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

John B. Laurie

13. Birthplace

Pa.

MOTHER

14. Maiden name

Maria Sumner

15. Birthplace

Maryland

16. Informant

John B. Laurie

Address

446 Lafayette St. Harde de Grace

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

3/19/47
(month) (day) (year)

Cemetery or crematory

Swan Creek

Location

Swan Creek Md.

18. Funeral director

Address

Pennington & Son
Harde de Grace, Md.

19. Date

Mar. 18, 1947
(Date rec'd by registrar)A. L. Lewis M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

3-16

19

47 at 3:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-18

19

46 to 3-16

19

and that I last saw him

alive on

3-12

19

Immediate cause of death

Sarcoma
of jejunum. Surgeon's report.

DURATION

oneyear

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

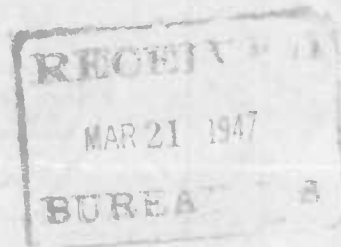
23. SIGNATURE

E. J. Simon

M. D. or other

Address

Harde de GraceDate signed 3-18-47



1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

02894

CERTIFICATE OF DEATH

Reg. Dist. No. 1821

1. PLACE OF DEATH:

County Harford
City or town Kalmar, Bel Air Road
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Harford Convalescent Home
How long in hospital or institution? 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Harford
City or town Abingdon
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary Alice Lee

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Frank A. Lee

7. Birth date of deceased (mo., day, yr.) May 3 1861 6.(c) If alive, give age _____ years

8. AGE: Years 85 Months 10 Days 26 If less than one day _____ hrs. _____ min.

9. Birthplace Harford County, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name William T. Hamilton

13. Birthplace Maryland

14. Maiden name Sarah Shay

15. Birthplace Maryland

16. Informant Granville Lee

Address Abingdon Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Apr 1 1947
(Month) (day) (year)

Cemetery or crematory Mountain Christian

Location Joppa R.D. Md

18. Funeral Director Howard S. McComastern

Address Abingdon Maryland

19. 4/3 47 Piscilla Howard
(Date rec'd by registrar) (Year) (Month) (Day) (Name of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1947 at 8:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 23 1947 to Mar 29 1947
and that I last saw her alive on March 28 1947

Immediate cause of death Coronary occlusion DURATION 30 min

Due to _____

Due to _____

Other conditions Lobar pneumonia 5 da.

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Willard P. Hudson M. D. or other _____

Address Forest Hill Md Date signed 3/29/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 5 1947

BUREAU OF B.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 830

02895

1. PLACE OF DEATH:

County Harford
 City or town Upper x Roads
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Harford
 City or town Upper x Roads
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Fred Lewis

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Ella Ellis
 7. Birth date of deceased (mo., day, yr.) March 18 1899 6.(c) If alive, give age years
 8. AGE: Years 48 Months 0 Days 0 If less than one day hrs. min.

9. Birthplace Ash co N.C.
 (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

12. Name not known

13. Birthplace

14. Maiden name

15. Birthplace Ash co N.C.

16. Informant Thomas R Lewis

Address Baldwin Rd. Md

17. Burial Burial Date thereof March 20 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Upper x Roads Baptist

Location Baldwin Rd. Md.

18. Funeral director Martin Skurtz

Address Janettsville Md.

19. March 20 1947 Thomas R Brown
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1947 at 4:45 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 17 1947 to March 17 1947
 and that I last saw him alive on March 17 1947

Immediate cause of death Pulmonary edema

Due to Rheumatic heart disease

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles D. Hoff M.D.
 M. D. or other

Address Street Md. Date signed 3-18-47

RECEIVED

MAR 25 1947

RECEIVED

1-55

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
year of birth shown on
film #109. 3/19/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (956)

CERTIFICATE OF DEATH

Reg. Dist. No. 1820

1. PLACE OF DEATH:

County Harford
City or town Bel Air
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Harford
City or town Abingdon
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mary E. Magness
4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
8.(b) Name of husband or wife John Magness
B.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 15, 1858

8. AGE: Years 89 Months 5 Days 23 If less than one day
..... hrs. min.

9. Birthplace Harford, Harford Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Thomas Clark

13. Birthplace Ireland

14. Maiden name Grace Brownfield

15. Birthplace Ireland

16. Informant Carolene Magness

Address Abingdon Maryland

17. Burial Date thereof Mar. 11, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Francis

Location Abingdon Maryland

18. Funeral director Frank R. M. Brown

Address Abingdon Maryland

19. 3/10 47 Priscilla Toward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 19 47, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 1 19 46, to March 8 19 47

and that I last saw him alive on 19

Immediate cause of death

Arteriosclerotic cv
disease

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lerald C Palmer M.D.

Address Bel Air, Md. M. D. or other

Date signed 3/10/47

UNITED STATES GOVERNMENT

STANDARD FORM NO. 64

OFFICE OF THE SECRETARY OF THE INTERIOR

DEPARTMENT OF THE INTERIOR

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

RECEIVED

MAR 12 1947

RECEIVED

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-2

CERTIFICATE OF DEATH

02897

Reg. Dist. No. 1820

1. PLACE OF DEATH:

County Hartford
 City or town Forest Hill
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Hartford
 City or town Rural - Forest Hill, md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Ella McConnell

3. (b) Social Security Number

4. Sex Female 5. Color or race Wh 6.(a) Single, married, widowed, or divorced UNKNOWN
 6.(b) Name of husband or wife John McConnell
 7. Birth date of deceased (mo., day, yr.) Dec 23 1861 6.(c) If alive, give age _____ years
 8. AGE: Years 85 Months 3 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Frenchtown N. J.
 (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Gabriel Slater
 13. Birthplace N. J.
 MOTHER 14. Maiden name Unknown
 15. Birthplace Cyrus Rister N.Y.C.

16. Informant Frenchtown
 Address Frenchtown

17. Burial Date thereof March 18, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Frenchtown

Location Frenchtown N. J.

18. Funeral director Diana Foster

Address Belair md

19. 3/16 47 Priscilla Howard
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1947 at 1:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to Mar 15 1947 and that I last saw her alive on March 14 1947

Immediate cause of death Chr. Myocardial Disease DURATION 5 yrs

Due to _____

Due to _____

Other conditions Essential Hypertension ?

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Willard P. Hudson M. D. or other

Address Forest Hill, md Date signed 3/15/47

RECEIVED

MAR 18 1947

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1172

CERTIFICATE OF DEATH

Reg. Diat. No. 02898 1850

1. PLACE OF DEATH:

County Harpur
 City or town Home A. Chase
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 hr
 Hospital, institution, or street address where death occurred:
Harpur Mem. Hosp
 How long in hospital or institution? 12 hr

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD County Harpur
 City or town Home A. Chase
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Gower Hill
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

George McLain

3. (b) Social Security Number

213-30-3743

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MCS

B. (b) Name of husband or wife

B. (c) If alive, give age. — years7. Birth date of deceased (mo., day, yr.) About 46 yrs. 19008. AGE: Years Months Days If less than one day
Unknown hrs. min.9. Birthplace Unknown
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant George McLainAddress Gower Hill, Home A. Chase17. Burial (Burial, cremation, or removal, which?) Date thereof 3/7/47
(month) (day) (year)Cemetery or crematory St. JamesLocation Home A. Chase18. Funeral director Funerary Co. (Rm)Address Home A. Chase19. March 6 1947 A. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4 1947 at 3⁰⁰ A. M.21. I CERTIFY that death occurred on the data above stated; that I attended deceased from 3/3 1947 to 3/4 1947
and that I last saw h. — alive on 3/4 1947Immediate cause of death Hypostatic pneumonia and
Pulmonary Edema DURATION 12 hr
Due to Ruptured Gastric ulcer 3 or 4 days
and PerforatedDue to
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Ruptured ulcer +
Perforated Date of op. 3/4/47Autopsy results Ruptured Gastric ulcer

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dudley Philbin MD M. D. or other
Address Harpur Mem Hosp Date signed 3/6/47

RECEIVED
SEP 8 1947
BUREAU OF

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

02899

Reg. Dist. No. 1830

1. PLACE OF DEATH:

County Harford
 City or town Rocks (Rural)
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County HarfordCity or town Rocks (Rural)
 (If outside city or town limits, write RURAL and give nearest town)Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Lillian C. Mulligan

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Allen C. Mulligan6. (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.)

Feb 7 1901

8. AGE:

Years	Months	Days	It less than one day
<u>46</u>	<u>1</u>	<u>22</u>	hrs. min.

9. Birthplace

Edgewood Harford Co Md.
 (Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

J. Sanford Desbrow

13. Birthplace

Michigan

MOTHER

14. Maiden name

Sara E. Griffith

15. Birthplace

Bolton Md.

16. Informant

Allen C. Mulligan

Address

Rocks Md.

17. Burial

Apr 1 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Wm Waters mem.

Location

coftown Harford Co Md

18. Funeral director

Marion Exum

Address

Garrettsville Md.

19. Date rec'd by registrar

Apr 1 1947

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1947 at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 5 1946 to March 29 1947
 and that I last saw him alive on March 28 1947

Immediate cause of death

Ch. Myocardial Disease
Ch. Bronchial Asthma

DURATION

5 yrs
12 yrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

Willard P. Hudson
 M. D. or otherAddress Forest Hill Md Date signed 3/30/47

RECEIVED

APR 5 1947

BUREAU P. S.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 890

CERTIFICATE OF DEATH

02900

Reg. Dist. No. 1850

1. PLACE OF DEATH:

County Harford
 City or town Harvards Grace
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Summer

Hospital, institution, or street address where death occurred:

406 No. Union Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Harford
 City or town Harvards Grace
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 406 No. Union Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Creswell Owens

3. (b) Social Security Number

4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Jesse A. Owens6. (c) If alive, give age 65 years7. Birth date of deceased (mo., day, yr.) July 31, 18828. AGE: Years 64 Months 7 Days 20 If less than one day _____ hrs. _____ min.9. Birthplace Cecil Co.
(Town, county, and state)10. Usual occupation House Duties11. Industry or business James Creswell12. Name James Creswell13. Birthplace Md.14. Maiden name unk.15. Birthplace Md.16. Informant Jesse A. OwensAddress Harvards Grace Md.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Mar. 16, 1947
(month) (day) (year)Cemetery or crematory Harvards GraceLocation Cecil Co. Md.18. Funeral director P. Madison MitchellAddress Harvards Grace Md.19. Mar. 15 1947 A. T. Lewis No. 1
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 13 1947 at 1:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19. 46 to Mar. 13 1947 and that I last saw him alive on Mar. 13 1947Immediate cause of death Cerebral Hemorrhage

Due to _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE E. J. Simon M. D. or other _____Address Harvards Grace Date signed 3-15-47

RECEIVED
MAR 18 1947
BUREAU OF

1-55

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53

CERTIFICATE OF DEATH

02901

Reg. Dist. No. 182

1. PLACE OF DEATH *Harford*
 County.....
 City or town..... *Forest Hill*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *13 years*
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State *Maryland* County *Harford*
 City or town..... *Forest Hill*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME *John W Peterson*

3. (b) Social Security Number

4. Sex *M* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *W*
 6. (b) Name of husband or wife *Grace L Debow*
 7. Birth date of deceased (mo., day, yr.) *Mar 23 - 1864* 6. (c) If alive, give age..... years
 8. AGE: Years *82* Months *11* Days *21* If less than one day
 hrs. min.

9. Birthplace *Harford Co. Md*
 (Town, county, and state)

10. Usual occupation *Retired*

11. Industry or business

FATHER 12. Name *James Peterson*
 13. Birthplace *England*
 MOTHER 14. Maiden name *Rebecca Tabbe*
 15. Birthplace *Md*

16. Informant *Mrs W Norris*
 Address *Forest Hill, Md*

17. Burial (Burial, cremation, or removal. Which?) *Burial* Date thereof *Mar 16/47*
 (month) (day) (year)
 Cemetery or crematory *Nt Tabor*
 Location *Gibson, Md*

18. Funeral director *Dean & Foster*
 Address *Bel Air Md*

19. *3/15* *47* *Priscilla Forward*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *March 14* 19 *47* *12:05 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 19 *46* to *March 13* 19 *47*
 and that I last saw him alive on *March 13* 19 *47*

Immediate cause of death *Bronch pneumonia*

Due to *Carcinoma of face*

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE *Robert A. Barthel MD*

Address *Forest Hill, Md* M. D. or other
 Date signed *3/14/47*

RECEIVED

MAR 18 1947

BUREAU V S

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

Reg. Diat. No.

02902

18/0

1. PLACE OF DEATH:

County.....Harford.
 City or town.....Berkside.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

113 Law St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Harford.City or town.....Berkside
 (If outside city or town limits, write RURAL and give nearest town)Street No. 113 Law St.
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Annie A. Preston

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

J. Robert Preston

7. Birth date of deceased (mo., day, yr.)

August 27, 1861

6. (c) If alive, give age..... years

8. AGE:

Years

85

Months

6

Days

If less than one day

hrs.

min.

9. Birthplace

Baltimore, Balto Co., Md.

(Town, county, and state)

10. Usual occupation

At home

11. Industry or business

12. Name

Theodore Gerhard

13. Birthplace

Germany

14. Maiden name

Unknown

15. Birthplace

Germany

16. Informant

Miss Lydia Preston

Address

Quial

(Burial, cremation, or removal. Which?)

Date thereof

Mar. 9, 1947

(month) (day) (year)

Cemetery or crematory

Bakers

Location

Berkside

18. Funeral director

Henry Taxing & Sons

Address

Berkside, Md.19. Mar. 8, 1947

(Date rec'd by registrar)

Nellie H. Piley

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 6, 1947 at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 19, 44 to Mar 6, 1947and that I last saw him alive on Mar 6, 1947Immediate cause of death Cardiac Failure

DURATION

Due to Coronary heart disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE

EB Graham MDAddress Aberdeen MdDate signed 3-7-47

RECEIVED

MAR 13 1947

BUREAU V B

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 02903 1550

1. PLACE OF DEATH: County..... <u>Harford</u> City or town..... <u>Havre de Grace</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>Two Days</u> Hospital, institution, or street address where death occurred: <u>Harford Memorial Hospital</u> How long in hospital or institution?..... <u>Two Days</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Cecil</u> City or town..... <u>Perryville</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3.(a) FULL NAME <u>Dominicco Rapposelli</u>				3.(b) Social Security Number			
4. Sex Male 5. Color or race Italian 6.(a) Single, married, widowed, or divorced Married				MEDICAL CERTIFICATION			
6.(b) Name of husband or wife <u>Angelina Rapposelli</u> 6.(c) If alive, give age <u>67</u> years				2D. DATE OF DEATH <u>10 March</u> 19 <u>47</u> at <u>6 7</u> M			
7. Birth date of deceased (mo., day, yr.) <u>August 5, 1875</u>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>October</u> 19 <u>46</u> to <u>March</u> 19 <u>47</u> and that I last saw him alive on <u>6 March</u> 19 <u>47</u> Immediate cause of death <u>Cardiac Failure</u>			
8. AGE: Years <u>71</u> Months <u>7</u> Days <u>5</u> If less than one day..... hrs. min.				DURATION			
9. Birthplace <u>Italy</u> (Town, county, and state)				Due to <u>Cerebral Hemorrhage</u> <u>(R. middle meningeal artery)</u>			
1D. Usual occupation <u>Laborer</u>				Due to			
11. Industry or business <u>P.R.R. Retired</u>				Other conditions			
12. Name <u>Serafino Rapposelli</u>				(Include pregnancy within 3 months of death)			
13. Birthplace <u>Italy</u>				Major findings of operations			
14. Maiden name <u>Rita Ciccotosto</u>				Date of op.			
15. Birthplace <u>Italy</u>				Autopsy results			
16. Informant <u>Yola Rapposelli Notarcola</u> Address..... <u>Perryville, Maryland</u>				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
17. Burial <u>March 13, 1947</u> (Burial, cremation, or removal. Which?) Cemetery or crematory..... <u>Mt. Erin</u> Location..... <u>Havre de Grace, Md. Rural</u>				22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of Where did injury occur?..... (City or town)..... (County)..... (State)..... Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....			
18. Funeral director <u>W. A. Patterson & Son</u> Address..... <u>Perryville, Md.</u>				23. SIGNATURE <u>W. H. Sadovinsky MD</u> Address..... <u>Perryville, Md.</u> Date signed..... <u>14 Mar '47</u>			
19. 3-12 <u>47</u> <u>A. L. Lewis M.D.</u> (Date rec'd by registrar)..... Registrar							

RECEIVED

MAR 14 1947

BUREAU V S.

1-38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and verily.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County.....*Harford*
 City or town.....*Whitford P.O.*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....*22 days*
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....*md* County.....*Harford*
 City or town.....*Whitford, md P.O.*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION).....*ms*
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Richard A. Ray

3. (b) Social Security Number

ms

4. Sex

M

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

None

7. Birth date of deceased (mo., day, yr.)

Dec 16, 1946.

8. AGE:

Years

Months

Days

If less than one day

*2**22*

hrs.

min.

9. Birthplace

Harford Co. Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

None

FATHER

12. Name

George Y. Ray

13. Birthplace

Ashe Co. N.C.

MOTHER

14. Maiden name

Virginia D Miller

15. Birthplace

Wilkes Co N.C.

16. Informant

George Y. Ray

Address

Whitford, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Mar 14 1947

(month) (day) (year)

Cemetery or crematory

Beamer Creek Cem.

Location

West Jefferson, P.O. N.C.

18. Funeral director

Hubert P Hopkins

Address

Delta Ray

19. March 18, 1947

(Date rec'd by registrar)

M. V. Kirda

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*March 8, 1947* at *2:00* P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 16, 1946

to

March 8, 1947

and that I last saw him alive on

March 7, 1947

Immediate cause of death

Bronchial pneumonia

DURATION

1 day

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

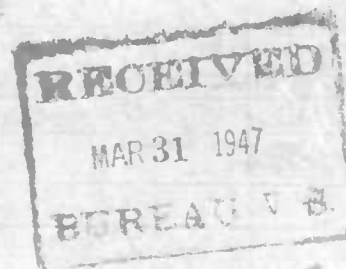
23. SIGNATURE

Lonnie A Hunt M.D.

M. D. or other

Address.....

*Delta, Pa.*Date signed *3/8/47*



2-25

2-1820-2-10

PLEASE WRITE PLAINLY, WITH **CONFIRMING INK**. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

Reg. Dist. No.

02905

1850

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

It less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. March 4

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

SIGNATURE

M. D. or other

Address

Date signed

RECEIVED

MAR 6 1947

BUREAU V.B.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 02906 1821

1. PLACE OF DEATH

County Harford
 City or town Baltimore Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years 8 mos.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Baltimore Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Paula O. E. Schuermann

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife William Schuermann
 6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1861

8. AGE: Years 85 Months 5 Days 11 If less than one day hrs. min.

9. Birthplace Wesel Germany
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name Unknown

15. Birthplace

16. Informant Mrs. William Schuermann

Address Baltimore R.D. Md

17. Cremation Date thereof Mar 21, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory London Park

Location Baltimore Md

18. Funeral director Howard K. McComester

Address Abingdon Maryland

19. Mar. 24 19 47 M. W. Kirk
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 19 47 at 5:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 43 to March 19 47
 and that I last saw him alive on March 17 19 47

Immediate cause of death

Pulmonary edema DURATION 2 hrs

Due to as auto stroke C-V

Due to Dissecting DURATION 3 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE J. Ralph Horky M.D. or other

Address Churchville Md Date signed March 21

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECORDED
MAR 31 1947
BUREAU V 8

2-1820-2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1820

1. PLACE OF DEATH:

County Harford
 City or town Kalmar, Belair R.D.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? six days

3. (a) FULL NAME

Harvey Elden Sheridan

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Hattie P. Mohan

7. Birth date of deceased (mo., day, yr.) Sept. 25 1874

8. AGE: Years 72 Months 3 Days 22 If less than one day
 hrs. min.

9. Birthplace Harford Co. Md
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name James Sheridan

13. Birthplace Harford Co. Md

14. Maiden name May Katherine James

15. Birthplace Harford Co. Md

16. Informant James E. Sheridan

Address Belair R.D. Md

17. Buried Date thereof Mar 20 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Smith's Chapel

Location Churchville Maryland

18. Funeral director Howard K. McCormick

Address Abingdon Maryland

19. 3/24 19 47 Priscilla Louwood
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Harford

City or town Aberdeen R.D.
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 17 19 47, at 7:53 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct 19 39, to March 19 47
 and that I last saw him alive on March 10 19 47

Immediate cause of death _____ DURATION _____

Acute Pulmonary edema _____

Due to arterio-sclerotic C.V. Disease psy

Due to _____

Other conditions Hypertrophied prostate

(Include pregnancy within 3 months of death)

Major findings of operations _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Reple Horky M. D. or other _____

Address Churchville Md Date signed March 19

RECEIVED

MAR 25 1947

BUREAU

1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16438

CERTIFICATE OF DEATH

Reg. Dist. No. 1850

1. PLACE OF DEATH
 County Harford
 City or town Bellevue de Chase
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 day
 Hospital, institution or street address where death occurred:
Harford Memorial Hospital
 How long in hospital or institution? 2 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md. County Harford
 City or town Belcamp
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME Ellen Smith 3. (b) Social Security Number _____

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Separated
 6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) 1897 6. (c) If alive, give age _____ years

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hrs. _____ min.
About 50

9. Birthplace Ramoth Co. N. C.
 (Town, county and state)

10. Usual occupation Shoemaker

11. Industry or business _____

12. Name Marck Rich

13. Birthplace North Carolina

14. Maiden name Julia Smith

15. Birthplace North Carolina

16. Informant Dallas Smith (Brother)

Address Ramoth County N.C. Maryland

17. Burial Burial Date thereof 4/4/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Harford

Location Harford N. C.

18. Funeral director Pennington & Row

Address Harford Md.

19. April 1 19 47 G. D. Lewis Jr.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 19 47 at 4:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____ and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death Pulmonary edema

Due to Drowning

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results Pulmonary edema - Corrosion of liver

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 3/30/47

Where did injury occur? Belcamp Harf. Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Belcamp River

Means of injury Walked into water Injured at work? No

23. SIGNATURE J. Ramsey M.D.

Dep. Med. Examiner M. D. or other

Address Aberdeen, Md. Date signed 4/1/47

RECEIVED
APR 3 1947
BUREAU V S

1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

02909

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Harford
City or town Fallston, Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Fallston
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Theodore Julius Stempel

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Henrietta

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30, 1854

8. AGE: Years 92 Months Days If less than one day hrs. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual occupation retired

11. Industry or business

12. Name Theodore J. Stempel

13. Birthplace Germany

14. Maiden name Wrightman

15. Birthplace Md

16. Informant Mrs Anna Stempel

Address Fallston, Md

17. Burial Date thereof 3-28-47
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory London Park

Location Baltimore, Md

18. Funeral director Leonard J. Ryck

Address 5305 Harford Rd

19. Mar 22 19 47 A.W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 19 47 at 3:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7, 1942 to March 21, 1947

and that I last saw him alive on March 21, 1947

Immediate cause of death Acute Bronchopneumonia

chronic DURATION 3 days

Due to

Due to

Other conditions Coronary Sclerosis Heart Disease

(Include pregnancy within 3 months of death)

Major findings of operations:

..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide,

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature Edward F. Hudson, M.D. M. D. or other

Address Fork 5th Date signed 3/21/47

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02910

CERTIFICATE OF DEATH

Reg. Dist. No. 1830

1. PLACE OF DEATH:

County WaldorfCity or town Brownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

1947

Mar

H

1947

Home

R

Brown

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

1947

at

4 A

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 28

1947

to

March 1

1947

and that I last saw him alive on Feb 28

DURATION

10 years

Immediate cause of death

Valvular heart disease,
mitral stenosis, with
decompensation

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Stewartstown Pa

Date signed

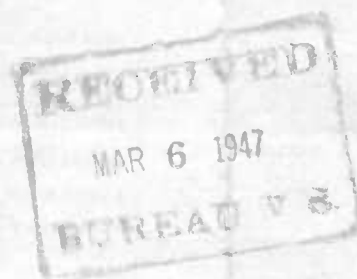
1 Mar 47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

Reg. Dist. No. 02911
1820

1. PLACE OF DEATH:

County Harford
 City or town Rural Ruthledge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
Farm of James Ely.
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md. County Baltimore
 City or town Rural Cockeysville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Seretta Leona Wade
 4. Sex F. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Single

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1947 at 7:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____
 and that I last saw him _____ alive on _____ 19____

Immediate cause of death Pneumonia
malnutrition

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. D. Ramsey M. D.Address Akron, Md. Date signed 3/1/47

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1946 6.(c) If alive, give age _____ years8. AGE: 2 Years 13 Months hrs. m/in.9. Birthplace Ashe Co. North Carolina
(Town, county, and state)10. Usual occupation Infant

11. Industry or business _____

FATHER 12. Name Leonard Wade13. Birthplace West VirginiaMOTHER 14. Maiden name Ruby Cox15. Birthplace Ashe Co. North Carolina16. Informant Leonard WadeAddress Knox Ave., Cockeysville, Md.17. Burial, cremation, or removal, Which? Burial Date thereof Mar. 4, 1947
(month) (day) (year)Cemetery or crematory Grace, Cockeysville, Md.Location Sanborn M. Brooks18. Funeral director Spauls, Md.

Address _____

19. 3/6/47 19 Pneilla Townsend
(Date rec'd by registrar) Registrar

RECEIVED

MAR 7 1947

BUREAU V S.

1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 1850

1. PLACE OF DEATH: *Harford*
 County.....
 City or town.....*Harre Rd. Grace*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....*18 hrs.*
 Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
 How long in hospital or institution?.....*18 hrs.*

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State.....*Maryland* County.....*Cecil*
 City or town.....*Perryville*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Baby Wasileski

3. (b) Social Security Number

4. Sex.....*Female* 5. Color or race.....*white* 6. (a) Single, married, widowed, or divorced.....*S*
 6. (b) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.).....*March 22, 1947.* 8. (c) If alive, give age..... years
 8. AGE: Years..... Months..... Days..... If less than one day.....*18* hrs. min.

9. Birthplace.....*Harre Rd. Grace, Harford Co. Md.*
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....*Chester W. Wasileski*
 13. Birthplace.....*Wilkes Barre, Pa*
 14. Maiden name.....*Helen D. White*
 15. Birthplace.....*Perryville, Md.*

16. Informant.....*Chasie Bruno.*
 Address.....*Perryville, Md.*

17. (Burial, cremation, or removal, Which?).....*Burial* Date thereof.....*March 23, 47.*
 (month) (day) (year)

Cemetery or crematory.....*Principis*
 Location.....*Principis Funeral, Md.*

18. Funeral director.....*Kela Pattison & Son*
 Address.....*Perryville, Md.*

19. *Mar. 23* 19 *47* *A. L. Lewis Jr.*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*3/22* 19 *47* at *11 P.* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
3/22 19 *47* to *3/22* 19 *47*
 and that I last saw him alive on *3/22* 19 *47*

Immediate cause of death.....

DURATION

Premature *18 hrs*

Due to.....
 Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*Dudley Phillips MD* M. D. or other
 Address.....*Harford Mem. Hosp.* Date signed.....*3/23/47*

RECEIVED

MAR 25 1947

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

CERTIFICATE OF DEATH

02913

Reg. Dist. No. 180

1. PLACE OF DEATH:

County... Harford Co
 City or town... Joppa
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 22 yrs
 Hospital, institution, or street address where death occurred: at home
 How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... md County... Harford
 City or town... Joppa
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Old Phila Rd
 (If rural, give LOCATION)
 2.(a) If veteran, name war... no

3. (a) FULL NAME

Emma Elizabeth Loge Webb

3. (b) Social Security Number

none

4. Sex... Female 5. Color or race... White 6.(a) Single, married, widowed, or divorced... Married
 6.(b) Name of husband or wife... D Stuart Webb
 6.(c) If alive, give age... 61 years
 7. Birth date of deceased (mo., day, yr.)... Apr-Feb/28/1877
 8. AGE: Years... 70 Months... 0 Days... 2 Less than one day... hrs. min.

9. Birthplace... Stanton Va
 (Town, county, and state)

10. Usual occupation... none

11. Industry or business... none

12. Name... John B Loge

13. Birthplace... Virginia

14. Maiden name... Fanny Jordan

15. Birthplace... Virginia

16. Informant... Mr. D S Webb (husband)

Address... Joppa Md

17. Burial... Burial Date thereof... 3-4-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Stanton (?)

Location... Stanton - Va

18. Funeral director... Stuart Webb

Address... 108 W North Baltimore

19. March 4 19 47 A. W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... March 2 19 47, at 11:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20 19 45, to March 2 19 47

and that I last saw her alive on March 1 19 47

Immediate cause of death... Congestive Heart Failure

Due to... Arteriosclerosis of

Due to... Heart

Other conditions... none

(Include pregnancy within 3 months of death)

Major findings of operations... none

Date of op... none

Autopsy results... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... none Date of... none

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Edward J. Hudson, MD

Address... 108 W North Baltimore

Date signed... 3/2/47

24. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20 19 45, to March 2 19 47

and that I last saw her alive on March 1 19 47

Immediate cause of death... Congestive Heart Failure

Due to... Arteriosclerosis of

Due to... Heart

Other conditions... none

(Include pregnancy within 3 months of death)

Major findings of operations... none

Date of op... none

Autopsy results... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... none Date of... none

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Edward J. Hudson, MD

Address... 108 W North Baltimore

Date signed... 3/2/47

24. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20 19 45, to March 2 19 47

and that I last saw her alive on March 1 19 47

Immediate cause of death... Congestive Heart Failure

Due to... Arteriosclerosis of

Due to... Heart

Other conditions... none

(Include pregnancy within 3 months of death)

Major findings of operations... none

Date of op... none

Autopsy results... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... none Date of... none

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Edward J. Hudson, MD

Address... 108 W North Baltimore

Date signed... 3/2/47

24. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20 19 45, to March 2 19 47

and that I last saw her alive on March 1 19 47

Immediate cause of death... Congestive Heart Failure

Due to... Arteriosclerosis of

Due to... Heart

Other conditions... none

(Include pregnancy within 3 months of death)

Major findings of operations... none

Date of op... none

Autopsy results... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... none Date of... none

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Edward J. Hudson, MD

Address... 108 W North Baltimore

Date signed... 3/2/47

24. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20 19 45, to March 2 19 47

and that I last saw her alive on March 1 19 47

Immediate cause of death... Congestive Heart Failure

Due to... Arteriosclerosis of

Due to... Heart

Other conditions... none

(Include pregnancy within 3 months of death)

Major findings of operations... none

Date of op... none

Autopsy results... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... none Date of... none

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Edward J. Hudson, MD

Address... 108 W North Baltimore

Date signed... 3/2/47

24. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20 19 45, to March 2 19 47

and that I last saw her alive on March 1 19 47

Immediate cause of death... Congestive Heart Failure

Due to... Arteriosclerosis of

Due to... Heart

Other conditions... none

(Include pregnancy within 3 months of death)

Major findings of operations... none

Date of op... none

Autopsy results... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... none Date of... none

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Edward J. Hudson, MD

Address... 108 W North Baltimore

Date signed... 3/2/47

24. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20 19 45, to March 2 19 47

and that I last saw her alive on March 1 19 47

Immediate cause of death... Congestive Heart Failure

Due to... Arteriosclerosis of

Due to... Heart

Other conditions... none

(Include pregnancy within 3 months of death)

Major findings of operations... none

Date of op... none

Autopsy results... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... none Date of... none

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Edward J. Hudson, MD

Address... 108 W North Baltimore

Date signed... 3/2/47

24. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20 19 45, to March 2 19 47

and that I last saw her alive on March 1 19 47

Immediate cause of death... Congestive Heart Failure

Due to... Arteriosclerosis of

Due to... Heart

Other conditions... none

(Include pregnancy within 3 months of death)

Major findings of operations... none

Date of op... none

Autopsy results... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... none Date of... none

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Edward J. Hudson, MD

Address... 108 W North Baltimore

Date signed... 3/2/47

24. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20 19 45, to March 2 19 47

and that I last saw her alive on March 1 19 47

Immediate cause of death... Congestive Heart Failure

Due to... Arteriosclerosis of

Due to... Heart

Other conditions... none

(Include pregnancy within 3 months of death)

Major findings of operations... none

Date of op... none

Autopsy results... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... none Date of... none

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Edward J. Hudson, MD

Address... 108 W North Baltimore

Date signed... 3/2/47

24. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20 19 45, to March 2 19 47

and that I last saw her alive on March 1 19 47

Immediate cause of death... Congestive Heart Failure

Due to... Arteriosclerosis of

Due to... Heart

Other conditions... none

(Include pregnancy within 3 months of death)

Major findings of operations... none

Date of op... none

Autopsy results... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... none Date of... none

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 115

CERTIFICATE OF DEATH

02914

Reg. Dist. No. 1867

1. PLACE OF DEATH:

County Sarford
 City or town Lawre Be Grace
 (If outside city or town limits, write RURAL and give nearest town)
30445.
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Sarford
 City or town Lawre Be Grace
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 414 N. Stokes
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

3. (a) FULL NAME Bella W. Whitlock
 4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife W. Davis Whitlock
 7. Birth date of deceased (mo., day, yr.) April 16, 1884. 6. (c) If alive, give age 47 years
 8. AGE: Years 62 Months Days It less than one day
 hrs. min.

MEDICAL CERTIFICATION 47

20. DATE OF DEATH Mar 27 19 47 at 11:53 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 19 46 to Mar 27 19 47
 and that I last saw her alive on Mar 27 19 47

Immediate cause of death

Coronary Thrombosis
Myocardial Infarction
Coronary Atherosclerosis
 Due to Coronary Atherosclerosis
 Due to Coronary Atherosclerosis
 Other condition Cardiac Failure
 (Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE

Charles J. Foley M.D.
 M. D. or other
 Address Pharmaceutical Bureau Date signed Mar 3/29/47

9. Birthplace Civil Co. Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business
 12. Name Calvin W. Haddon
 13. Birthplace Civil Co. Md.
 14. Maiden name Leah Weir
 15. Birthplace Civil Co. Md.
 16. Informant Margaret Butler
 Address 414 Stokes St. Lawre Be Grace
 17. Funeral Date thereof March 30, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Asbury
 Location Burginville, Pailes, Md.
 18. Funeral director W. A. Patterson & Son
 Address Burginville, Md.
 19. Mar. 29 19 47 A. L. Lewis M.D.
 (Date rec'd by registrar) Registrar

RECEIVED

APR 2 1947

BUREAU

1-33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16374

CERTIFICATE OF DEATH

02915

Reg. Dist. No. 1850

1. PLACE OF DEATH
 County Harford
 City or town Hamde House
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Hamde House
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME Mary Youman

3. (b) Social Security Number _____

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced _____
 6. (b) Name of husband or wife George G. Youmans
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Aug 16 - 1896

8. AGE: Years 50 Months 7 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Charlottesville, Va., Md.
 (Town, county, and state)

10. Usual occupation Seamstress

11. Industry or business _____

12. Name Samuel J. Murphy

13. Birthplace Charlottesville

14. Maiden name Ellen Simpson

15. Birthplace North East

16. Informant George E. Youmans (Son)

Address 3 Walter Place, Forestville Conn.

17. Buried Date thereof 4/1/47
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Charlottesville

Location Charlottesville, Va., Md.

18. Funeral director Remington & Sons

Address Hamde House, Md.

19. Mar. 31, 1945 A. L. Lewis M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1947 at 3P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____
 and that I last saw h. _____ alive on _____ 19 _____

Immediate cause of death Poisoning by Carbon
Monoxide

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide suicide Date of 3/28/47

Where did injury occur? Hamde House, Harford, Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Turned on gas stove Injured at work? no

Acting Deputy Medical Examiner

23. SIGNATURE L. C. Palmer M.D.
Harford County M. D. or other _____

Address Bellaire, Md. Date signed 3/28/47

RECEIVED

APR 3 1947

BUREAU

1-35